STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290005	A. BUILDING _____ B. WING _____	C 04/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH VISTA HOSPITAL	1409 EAST LAKE MEAD BLVD NORTH LAS VEGAS, NV 89030

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A 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare Complaint Validation Survey conducted at your facility from 4/15/09 through 4/17/09. The survey was conducted in accordance with 42 CFR Part 482 - Hospitals. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The census on the first day of the survey was 114. 30 clinical records were reviewed. The Condition of Participation was not met for CFR 482.23 Nursing Services. The following complaint was investigated and found to be substantiated. Complaint #NV21147- substantiated (See Tags: A 0385, A 0395) The following regulatory deficiencies were identified.	A 000	**Complaint #NV21147** **Tag A385** **Temporary and Permanent Corrective Action.** **1.) How the correction was accomplished, both temporarily and permanently for each individual affected by the deficient practice, including any system changes that must be made.** **a. Failure to document nursing care and assessments thoroughly and act on declining status timely:** The following language has been added as a revision to the Plan for Provision of Patient Care and Services (Policy Number: ADM:00:01): Patients will receive the level of care that has been ordered by the physician (i.e., Med/Surg, Critical Care, and/or Geropsych). In instances where a physician has written an order to transfer a critical care patient from a lower level of care to a higher level of care, and the transferring unit has been notified of bed unavailability, the following component of the patient over-flow plan will be implemented: • Monitoring, assessments, interventions, evaluation of care, and documentation will be consistent with the level of care ordered by the physician. • Documentation will be completed in HED (electronic medical record system), under the ICU Flowsheet, for those staff who have HED access, and/or by using the downtime forms available through Optio (electronic print-on demand forms system). • Prior to transferring the patient to the temporary location, the Unit Secretary from the transferring unit will print the *Downtime Assessment, Charting and Interventions Form* and the *Vital Sign Downtime Form* as well as the patient's current MAR.	6/18/09
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by:	A 385	The Code Purple (rapid response team) policy (Policy Number: PCS:07:45) was reviewed and no changes were identified. The staff will be re-inserviced on the Code Purple policy and the criteria for initiating a Code Purple. Documentation requirements for the Code Purple will be emphasized during the inservice. Staff education will also be provided related to the revisions in the Plan for Provision of Patient Care and Services policy, specifically related to the initiation of	6/17/09 By 7/12/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 6/19/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 385	Continued From page 1 The facility failed to maintain compliance with the Condition of Participation for Nursing Services based on deficiencies cited at Tag A 395 including: Failure to document nursing care and assessments thoroughly and act on declining status timely. Failure to transfer the patient to an appropriate setting. Failure to monitor the patient in an appropriate setting. Failure to treat as ordered by the physician in a timely manner. Refer to Tag A 395. Complaint # NV 21147	A 385	the over-flow plan and documentation requirements. **b. Failure to transfer the patient to an appropriate setting:** The following language has been added as a revision to the Plan for Provision of Patient Care and Services (Policy Number: ADM:00:01): Patients will receive the level of care that has been ordered by the physician (i.e., Med/Surg, Critical Care, and/or Geropsych). In instances where a physician has written an order to transfer a critical care patient from a lower level of care to a higher level of care, and the transferring unit has been notified of bed unavailability, the following component of the patient over-flow plan will be implemented: • If there are no ICU beds available and there are more critical care patients needing beds, the Emergency Department may be used to hold the patient temporarily until a bed becomes available in the ICU. The ED will be staffed with one ICU nurse for 1 – 2 patients. A second nurse will be provided if there is a 3rd or 4th critical care patient holding. The ICU Director and/or the Nursing Supervisor will be notified of the need to implement the patient over-flow plan. • If the ED is at capacity and an ICU bed is not available, the PACU will be utilized as a secondary overflow area, staffed by critical care RNs (from ED, ICU, PACU, and/or the Nursing Supervisor). • The Charge Nurse and/or the primary nurse caring for the patient on the transferring unit will be responsible for notifying the physician of the bed unavailability in ICU and the temporary location where the patient has been transferred (i.e., ED or PACU). Staff education will also be provided, related to the revisions in the Plan for Provision of Patient Care and Services policy, specifically related to the initiation of the over-flow plan and documentation requirements. **c. Failure to monitor the patient in an appropriate setting:** The following language has been added as a revision to the Plan for Provision of Patient Care and Services (Policy Number: ADM:00:01):	6/18/09 By 7/12/09 6/18/09
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure accurate documentation for the supervision and evaluation for 1 of 30 patients sampled (#1). Findings include: Patient #1 Patient #1 was a 76 year old male admitted on 1/13/09 with diagnoses to include Chest Pain, history of Chronic Obstructive Lung Disease, Pulmonary Embolism, Congestive Heart Failure, Alzheimer's Disease and a history of Cardiac	A 395		

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A 395	Continued From page 2 Bi-pass Surgery. Patient #1 was noted to be Jaundiced in the Emergency Room on admission. Patient #1 was admitted to the ED on 1/13/09 at 12:28 PM by ambulance for a complaint of chest pain. The Emergency Room Nurse's Notes documented Patient #1's chest pain subsided approximately 10 minutes after he arrived. Patient #1 was admitted to the 2nd floor with telemetry on 1/13/09, as observation at 9:00 PM and later was changed (from a 23 hr observation status to a full admission status) to full status on 1/14/09 in the morning. The Nurse's Notes on the morning of 1/14/09, indicated Patient #1 was stable, on Oxygen at 2 liters via nasal cannula, telemetry and was receiving intravenous fluids (IV). The notes indicated he was drinking fluids and eating. The patient was noted to be responsive to verbal stimuli. A Physician's Order for Patient #1 dated 1/14/09, documented a "Transfer ICU (intensive care unit)." The order was acknowledged at 6:43 PM. On 1/14/09, the Nurse's Notes for Patient #1 documented the following: - 1437 (2:37 PM), "Offered Patient more juice. Drank 2 containers." - 1820 (6:20 PM), "Notified of ABG (arterial blood gas) status from lab (laboratory) Notified charge nurse. Dr. (name) on the floor, ordered stat (immediate) ABG and transfer to ICU." - 1840 (6:40 PM), "3 amps(ampules) of Sodium bicarb (bicarbonate) pushed stat as ordered." - 1845 (6:45 PM), "ICU nurse reported no beds available. Explained pt. (patient) ABG to family,	A 395	Patients will receive the level of care that has been ordered by the physician (i.e., Med/Surg, Critical Care, and/or Geropsych). In instances where a physician has written an order to transfer a critical care patient from a lower level of care to a higher level of care, and the transferring unit has been notified of bed unavailability, the following component of the patient over-flow plan will be implemented: • If there are no ICU beds available and there are more critical care patients needing beds, the Emergency Department may be used to hold the patient temporarily until a bed becomes available in the ICU. The ED will be staffed with one ICU nurse for 1 – 2 patients. A second nurse will be provided if there is a 3rd or 4th critical care patient holding. The ICU Director and/or the Nursing Supervisor will be notified of the need to implement the patient over-flow plan. • If the ED is at capacity and an ICU bed is not available, the PACU will be utilized as a secondary overflow area, staffed by critical care RNs (from ED, ICU, PACU, and/or the Nursing Supervisor). The Emergency Department and PACU have the same level of monitoring capabilities (i.e., equipment) as the ICU. The staff will be re-inserviced on the Code Purple policy and the criteria for initiating a Code Purple. Documentation requirements for the Code Purple will be emphasized during the inservice. Staff education will also be provided, related to the revisions in the Plan for Provision of Patient Care and Services policy, specifically related to the initiation of the over-flow plan and documentation requirements. **d. Failure to treat as ordered by the physician in a timely manner:** The following language has been added as a revision to the Plan for Provision of Patient Care and Services (Policy Number: ADM:00:01): Patients will receive the level of care that has been ordered by the physician (i.e., Med/Surg, Critical Care, and/or Geropsych). In instances where a physician has	By 7/12/09 By 7/12/09 6/18/09

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A 395	Continued From page 3 informed them pt. was going to ICU." - 1950 (7:50 PM), "Lab (laboratory) at bedside drawing blood pt. moving arms, this rn (Registered Nurse) at bedside helping to hold pt. arms so blood can be drawn." - 2000 (8:00 PM), "Pt. in mild respiratory distress on BiPAP (Bi-level Positive Airway Pressure) maintained iv (intravenous fluids) infusing per Md (doctor) order. Pt. drowsy but arouseable. Kept hob (head of bed) up in bed. " - 2020 (8:20 PM), "Icu charge rn here to start iv access needed for antibiotic therapy." - 2030 (8:30 PM), "Pt. on NPO (nothing by mouth) maintained." - 2040 (8:40 PM), "family at bedside supportive with care. pt still talks voice slow and garbled BiPAP maintained." - 2050 (8:50 PM), "icu (ICU) charge rn (Employee #2) still at bedside talked to family about pt's condition family already aware from day shift that pt will be transferred to icu as soon as bed is available and charge rn has talked to family about it." - 2100 (9:00 PM), "icu charge rn started an iv to lua (left upper arm) switch iv of ns (Normal Saline) to the lua iv site." - 21:25 (9:25 PM), "cath (catheter) discontinued intact no redness. icu charge (Employee #2) rn still on the unit made aware that the iv he just started is puffy." - 21:30 (9:30 PM), "iv to left upper arm puffy switch iv to lfa (left forearm) site." - 2130 (9:30 PM), "...3 amp bicarb hung at 2130..." - 2210 (10:10 PM), "... pt following commands BiPAP maintained following commands but goes back to dozed off on and off." - 2215 (10:15 PM), "First liter infused following bag iv rate decreased to 150 cc.hr."	A 395	written an order to transfer a critical care patient from a lower level of care to a higher level of care, and the transferring unit has been notified of bed unavailability, the following component of the patient over-flow plan will be implemented: • The Charge Nurse and/or the primary nurse caring for the patient on the transferring unit will be responsible for notifying the physician of the bed unavailability in ICU and the temporary location where the patient has been transferred (i.e., ED or PACU). A Chain of Command for Resolution of Issues policy has been developed and approved to provide a guideline for communicating information to a supervisor, director and/or physician, related to clinical issues such as changes in the patients condition and/or the initiation of the over-flow plan as defined in the Plan for Provision of Patient Care and Services (see Policy Number: ADM:00:01). The Code Purple (rapid response team) policy (Policy Number: PCS:07:45) was reviewed and no changes were identified. The staff will be re-inserviced on the Code Purple policy and the criteria for initiating a Code Purple. Documentation requirements for the Code Purple will be emphasized during the inservice. Staff education will also be provided, related to the revisions in the Plan for Provision of Patient Care and Services policy, specifically related to the initiation of the over-flow plan and documentation requirements. Staff education will also be provided for the new Chain of Command for Resolution of Issues policy, specifically related to the clinical chain of command for changes in the patient's condition or initiation of the over-flow plan. **2.) The title of position of the person responsible for correction.** The following will be responsible for the corrective action: a. Chief Nursing Officer **3.) A description of the monitoring process to prevent recurrences of the deficiency, the frequency of the monitoring and the individual(s) responsible for the monitoring.** Immediate monitoring will commence with a review of transfers to a higher level of care from a Medical,	6/18/09 6/18/09 By 7/12/09

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A 395	Continued From page 4 - 22:00 (10:00 PM) "Icu charge rn still attempting another iv access for antibiotics and eventually blood transfusion." - 2220 (10:20 PM), "pt. repositioned in bed hob maintained at 45 degrees pt has tendency to stay on his left side incontinent of urine pt cleaned and dried ivf infusing well pt. denies chest pain or sob (shortness of breath)." - 2240 (10:40 PM), "pt dozing on and off easily awaken breathing slightly labored BiPAP maintained." - 2300 (11:00 PM), "ivf and vancomycin infusing to 2 different sites to left leg sites clear. Pt remains drowsy but arouseable side rails Up x (times) 3 lung sounds diminished." - 2335 (11:35 PM),"this rn at bedside checking on pt's condition and at the same time, icu charge rn (Employee #2) at bedside states telemetry called him up for hr (heart rate) of 30. pt non responsive still has minimal shallow breathing no pulse code blue (cardiopulmonary resuscitation) called." The Nurse's Notes on 1/14/09, indicated at 8:44 AM Patient #1's blood pressure was 110/52 with a heart rate of 106. The next blood pressure noted was 95/43 at 8:41 PM with a heart rate of 106. There were no other recorded vital signs until the Code Blue at 11:35 PM when the patient was given 1 amp (ampule) of Epinephrine. The recorded blood pressure at 11:40 PM was 113/38. On 1/15/09 at 12:02 AM, the Nurse's Notes indicated Patient #1 was pronounced by the ED physician. During an interview on 4/17/09, Employee #1 indicated on 1/14/09, she was given a late report on Patient #1 because the nurse from the	A 395	Surgical and/or Geropsych clinical unit. This monitoring will include a review to ensure the patient was receiving appropriate higher level of care monitoring and documentation as defined by the critical care unit. Immediate and ongoing monitoring of Risk Management and patient complaint reports to ensure that chain of command and Code Purple is initiated in accordance with established policies, including the Plan for Provision of Patient Care and Services. This monitoring activity will be reported to the Hospital Quality Council, Medical Executive Committee, and Governing Board, not less than quarterly. **4.) The date when the immediate correction of the deficiency will be accomplished. Normally this will be no more than thirty (30) days from the date of the exit conference.** The Plan for the Provision of Patient Care and Services was revised and approved by hospital leadership on June, 18, 2009. The revised plan will be presented to the Medical Executive Committee for approval on July 8, 2009 and then to the Board on July 10, 2009. The Chain of Command for Resolution of Issues policy was approved by hospital leadership on June 18, 2009. The policy will be presented to the Medical Executive Committee for approval on July 8, 2009 and then to the Board on July 10, 2009. The monitoring of the transfers from a lower level of care to a higher level of care will commence on June 19, 2009.	6/18/09 7/8/09 7/10/09 6/18/09 7/8/09 7/10/09 6/19/09

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A 395	Continued From page 5 previous shift was still working on Patient #1. Employee #1 indicated she received report about the patient at 7:45 PM. Employee #1 indicated the day shift nurse told her Patient #1 had changes in his condition including labored breathing. Employee #1 indicated she had assessed him and noticed there was a change from the previous day. Employee #1 indicated, she had helped the lab technician draw blood because Patient #1 was very restless. She indicated the Patient was a "hard stick"(difficulty drawing blood). Employee #1 indicated Employee #2 arrived on the floor about 8:00 PM and tried to re-start an IV on Patient #1. The patient already had an IV, however the physician wanted another line for a blood transfusion that was ordered. Employee #1 indicated Employee #2 was aware the patient was to be transferred to the ICU when a bed became available and she indicated Employee #2 spoke to the family and explained the patient would be transferred to ICU as soon as a bed became available. Employee #1 indicated, Employee #2 called the Emergency Room to inquire if Patient #1 could be transferred to the ED. Employee #1 indicated the ED informed Employee #2 they had 2 patients on hold waiting to be transferred to ICU and the ED was full. Employee #1 indicated Employee #2 stayed on the floor for at least 2 hours and had to re-start the IV on Patient #1 several times before he was able to get 2 sites in the patient's left leg. Employee #1 revealed Employee #2 received a call from telemetry at 11:35 PM that Patient #1's heart rate was 30 and that Employee #2 called a Code Blue on the patient.	A 395	**Complaint #NV21147** **Tag A395** **Temporary and Permanently Corrective Action.** **1.) How the correction was accomplished, both temporarily and permanently for each individual affected by the deficient practice, including any system changes that must be made.** **Failure to ensure accurate documentation for the supervision and evaluation for 1 of 30 patients sampled:** The following has been added as a revision to the Plan for Provision of Patient Care and Services (Policy Number: ADM:00:01): Patients will receive the level of care that has been ordered by the physician (i.e., Med/Surg, Critical Care, and/or Geropsych). In instances where a physician has written an order to transfer a critical care patient from a lower level of care to a higher level of care, and the transferring unit has been notified of bed unavailability, the following component of the patient over-flow plan will be implemented: • Monitoring, assessments, interventions, evaluation of care, and documentation will be consistent with the level of care ordered by the physician. • Documentation will be completed in HED (electronic medical record system), under the ICU Flowsheet, for those staff who have HED access, and/or by using the downtime forms available through Optio (electronic print-on demand forms system). • Prior to transferring the patient to the temporary location, the Unit Secretary from the transferring unit will print the *Downtime Assessment, Charting and Interventions Form* and the *Vital Sign Downtime Form* as well as the patient's current MAR. The Code Purple (rapid response team) policy (Policy Number: PCS:07:45) was reviewed and no changes were identified. The staff will be re-inserviced on the Code Purple policy and the criteria for initiating a Code Purple. Documentation requirements for the Code Purple will be emphasized during the inservice.	6/18/09 6/18/09

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A 395	Continued From page 6 Employee #1 indicated she monitored Patient #1's vital signs on 1/14/09 every half hour and indicated she was so busy she must have forgotten to document the patient's blood pressure and heart rate in the Nurse's Notes. Employee #1 indicated Patient #1 received his antibiotics and fluids through the IV Employee #2 started in his leg. Employee #1 indicated, Employee #2 was in communication with the patient's physician, the ICU nurses and the Emergency Room in order to expedite a transfer for Patient #1. Employee #1 indicated the patient coded before he was able to receive the blood that was ordered and indicated she should have documented all of this information. An interview with the Director of Quality and the Director of Clinical Services for the 2nd floor on 4/17/09, indicated that the ICU RN Charge Nurse (Employee #2) did a lot of work on the patient and that he should have documented it in the chart. Complaint # NV21147	A 395	Staff education will also be provided, related to the revisions in the Plan for Provision of Patient Care and Services policy, specifically related to the initiation of the over-flow plan and documentation requirements. **2.) The title of position of the person responsible for correction.** The following will be responsible for the corrective action: a. Chief Nursing Officer **3.) A description of the monitoring process to prevent recurrences of the deficiency, the frequency of the monitoring and the individual(s) responsible for the monitoring.** Immediate monitoring will commence with a review of transfers to a higher level of care from a Medical, Surgical and/or Geropsych clinical unit. This monitoring will include a review to ensure the patient was receiving appropriate higher level of care monitoring and documentation as defined by the critical care unit. Immediate and ongoing monitoring of Risk Management and patient complaint reports to ensure that chain of command and Code Purple is initiated in accordance with established policies, including the Plan for Provision of Patient Care and Services. This monitoring activity will be reported to the Hospital Quality Council, Medical Executive Committee, and Governing Board, not less than quarterly. **4.) The date when the immediate correction of the deficiency will be accomplished. Normally this will be no more than thirty (30) days from the date of the exit conference.** The Plan for the Provision of Patient Care and Services was revised and approved by hospital leadership on June, 18, 2009. The revised plan will be presented to the Medical Executive Committee for approval on July 8, 2009 and then to the Board on July 10, 2009. The monitoring of the transfers from a lower level of care to a higher level of care will commence on June 19, 2009.	By 7/12/09 6/18/09 7/8/09 7/10/09 6/19/09